Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CENTRE FOR NEURO SKILLS
2658 MOUNT VERNON AVENUE
BAKERSFIELD CA 93306

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-3158-01

MFDR Date Received
May 17, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Negotiated rate effective 2-1-04. Payments I the amount of $487 Per Diem were received through 5-15-05. Requestor's amount billed is fair and reasonable for the services provided to patient, [injured employee]. These reasonable charges were agreed to by the carrier, and employer and under the agreement has been paid since 1994."

Amount in Dispute: $8,610.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Requestor charged a fee of $487 per day for its services and treatment of the Claimant. The services allegedly being provided and billed under CPT Code 97799 do not have an established Division maximum allowable reimbursement. Because there is not a maximum allowable reimbursement for the services, the amount to be reimbursed is the fair and reasonable amount for the services provided. However, and in order to determine the fair and reasonable amount, the Requestor is required to submit proper documentation." "Requestor did not provide proper supporting documentation. Their documentation generally describes a month of alleged activities; however, it does not adequately describe the day-to-day care and activities of the Claimant and how Requestor arrived at $487.00 per day to care for and provide a living environment for the Claimant." "Respondent relied upon its own methodology to determine a fair and reasonable rate of reimbursement. Respondent conducted a survey of the metropolitan area in which the services were provided, including a specific bid from a competing provider, and as a result determined that the reimbursement rate of $200 per day, was a fair and reasonable amount for medical services." "Requestor argued that they had a contract with Respondent which stated that a fee of $487 would be paid for each day the claimant remained at Requestor's facility. However, Requestor has not provided any contract signed by Respondent. Additionally, please see the attached Affidavit of Cindy Gowing which confirms that Respondent has consistently maintained that it would continue to be responsible for the care and treatment of the Claimant as provided by the Texas Workers' Compensation Act and not due to any alleged and unseen contract." "Further, please see attached internal communication from Requestor admitting that there was no negotiated contract with Respondent regarding the fees for treatment of the Claimant." "Additionally, Requestor failed to preauthorize the medical services.

Response Submitted by: Downs Stanford, PC, 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 1, 2010 – September 30, 2010	Assisted Living Services – CPT Code 97799	$8,610.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on May 17, 2011.
5. The services in dispute were reduced/denied by the respondent with the following reason codes.
    - 309 – The charge for this procedure exceeds the fee schedule allowance.
    - W1 – Workers Compensation State Fee Schedule adjustment.
    - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §133.307?
2. Did the requestor meet the requirements of 28 Texas Administrative Code §134.1 providing for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307 requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. In accordance with 28 Texas Administrative Code §133.307(c)(2)(A-B) the requestor did not submit a copy of the bill submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills), nor did the requestor submit a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB. Therefore, the requestor has not met the requirements of the rule.
2. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(E), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).
5. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses,

demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

- The requestor's position statement asserts that "Requestor's amount billed is fair and reasonable for the services provided to patient, [injured employee]. These reasonable charges were agreed to by the carrier, and employer and under the agreement has been paid since 1994."
- The requestor does not discuss or explain how $487.00 per day is a fair and reasonable reimbursement for the services in this dispute.
- In support of the requested reimbursement, the requestor submitted an explanation of benefits, from the insurance carrier for the injured employee showing payment in the full amount was made in May of 2009. However, the requestor did not discuss or explain how the sample EOB supports the requestor's position that additional payment is due. The carriers' reimbursement methodologies are not described on the EOB. Nor did the requestor explain or discuss the carriers' methodologies or how the payment amount was determined for the sample EOB.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 6, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.